FH
[redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: FCP - 177554

PRELIMINARY RECITALS

Pursuant to a petition filed on October 25, 2016, under Wis. Admin. Code § DHS 10.55, to review a decision by the Milwaukee Enrollment Services regarding Medical Assistance (MA), hearings were held on September 15, 2016, October 25, 2016 and December 6, 2016, at Milwaukee, Wisconsin. The record was held open post-hearing for additional documents from the agency.

The issue for determination is whether the agency properly determined the Petitioner's Family Care enrollment date.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: [redacted]
Milwaukee Enrollment Services
1220 W Vliet St
Milwaukee, WI 53205

ADMINISTRATIVE LAW JUDGE:
Debra Bursinger
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) was a resident of Milwaukee County. At all times pertinent here, Petitioner resided in an assisted living facility at [redacted] until May, 2016 when he moved to a skilled nursing facility.

2. On May 8, 2015, a referral was submitted by [redacted] on behalf of the Petitioner to the Aging Resource Center (ARC) of Milwaukee. An appointment was scheduled for the ARC to meet with the Petitioner on June 8, 2015. On May 18, 2015, the Petitioner cancelled the meeting with the ARC. On June 15, 2015, [redacted] made another referral to the ARC on behalf of the Petitioner.

3. On July 21, 2015, the ARC met with the Petitioner and his family. Petitioner signed a Family Care Enrollment application.

4. On July 22, 2015, a Long-Term Care Functional Screen was completed on the Petitioner. He was determined to be functionally eligible for Family Care.

5. On August 4, 2015, the ARC met with the Petitioner and his family at [redacted] and provided the necessary documents to apply for MA. On August 5, 2015, the Petitioner's representative faxed the completed MA application to the ARC.

6. On August 14, 2015, the income maintenance (IM) agency issued a Notice of Decision to the Petitioner informing him that his application for Medicare Premium Assistance benefits was denied due to income exceeding program limits.

7. On August 14, 2015, the IM agency issued a Notice of Proof Needed to the Petitioner requesting verification of life insurance policies and a pension/retirement account. The due date for the information was September 4, 2015. On or about August 18, 2015, the Petitioner provided the requested information.

8. On August 27, 2015, the agency issued a Notice of Decision to the Petitioner informing him that his August 5, 2015 application for MA was denied due to income and assets exceeding the program limits. In addition, the notice informed him that his application for Community Waivers was denied due to assets exceeding the program limit.

9. On August 27, 2015, the agency issued a notice of Information about Community Spouse Asset Share Calculation to the Petitioner informing him that the agency determined his total combined countable assets as of August 26, 2015 was $53,357.41. It informed him that to meet MA asset eligibility, he and his spouse could have $52,000 in assets.

10. On September 3, 2015, the Petitioner's representative contacted the IM agency three times. She did not receive a return call. She then contacted the ARC who told her they would get information about why the application was denied. The ARC did not return the call. When the Petitioner attempted to call back, she was advised that the case manager was on vacation until September 14, 2015.

11. On September 14, 2015, the Petitioner's representative contacted the ARC. She was advised to fax a bank statement as soon as possible so that the case would remain open. On September 15, 2015, the Petitioner provided additional bank statements to the ARC and IM agency.

12. On October 5, 2015, the Petitioner's representative received a phone call from [redacted] that the ARC called to inform them the Petitioner's case had been closed by "the state."

13. On October 7, 2015, the ARC contacted the Petitioner's representative and informed her that the Petitioner would need to file a new application. A list of the necessary documents for the filing

was provided. On October 13, 2015, the Petitioner's representatives filed another Family Care Enrollment application.

14. On November 5, 2015, another MA application was submitted on behalf of the Petitioner to the IM agency.

15. On November 9, 2015, the agency issued a Notice of Decision to the Petitioner's spouse. It informed her that the Petitioner's MA application of November 5, 2015 was denied due to income and assets exceeding the program limit. It further informed her that the application for Community Waivers was denied due to assets exceeding the program limit.

16. On November 13, 2015, the Petitioner's representative faxed additional documentation to the IM agency. She also attempted to contact the IM agency and never received a return call. She also contacted the ARC. The ARC advised her that Petitioner was over the asset limit by $1,396.15. She was advised to pay [redacted] $1,396.15 for Petitioner's care. Petitioner's representatives paid [redacted] that day and faxed a receipt to the IM agency.

17. On December 2, 2015, the ARC contacted the Petitioner's representative and informed her that he had received a "statement of asset overage" in the amount of $1,396.15. He stated he was unsure why and advised her that he would call the IM agency. Petitioner again faxed the receipt for the [redacted] check to the ARC.

18. On December 16, 2015 and December 29, 2015, the Petitioner's representative left messages for the ARC and received no return call.

19. On January 6, 2016, the Petitioner's representative received a voice message that the ARC worker she had been dealing with had retired. The new worker contacted her and advised her that the Petitioner was over the asset limit by $1,396.15. The new worker told her that if Petitioner and his spouse wanted to keep more than $52,000, it would have to be approved by a court or the MA program. The worker told the Petitioner's representative that she would call her back with more information. She never called back.

20. On January 19, 2016, the Petitioner's representative called the ARC worker and was advised a new Notice of Decision had been issued on January 18, 2016. She told the representative to contact the IM agency. The representative contacted the IM agency. She was advised she needed to file another MA application for the Petitioner. She completed a phone application and signature. She was advised that additional documents would be needed.

21. On January 20, 2016, the agency issued a Notice of Proof Needed to the Petitioner requesting verification of a savings account and life insurance policy. The due date for the information was February 18, 2016. The Petitioner provided the requested information on January 25, 2016.

22. On January 20, 2016, the agency issued a Notice of Decision to the Petitioner informing her that the MA application of January 19, 2016 was denied due to assets and income exceeding program limits.

23. On February 2, 2016, the agency issued a notice of Information about Community Spouse Asset Share Calculation informing the Petitioner's spouse that total combined countable assets as of Feb. 1, 2016 was $54,098.93. It further informed her that to meet MA asset eligibility, combined assets could not exceed $52,000.

24. On February 2, 2016, the agency issued a Notice of Decision to the Petitioner's wife informing her that the MA application of January 19, 2016 was denied due to assets and income exceeding program limits. It further informed her that the application for Community Waivers was denied due to assets exceeding the program limit.

25. On February 6, 2016, the Petitioner's representatives met with a former ESS worker who advised them to complete another MA application and asset assessment. On March 15, 2016, the

Petitioner's representatives submitted an MA Asset Assessment form and another MA application.

26. On March 21, 2016, a Notice of Proof Needed was issued to the Petitioner requesting additional information regarding a [redacted]. The due date for the information was April 15, 2016. On March 28, 2016, the Petitioner's representatives submitted the requested information.

27. On April 19, 2016, a Notice of Proof Needed was issued to the Petitioner's representative requesting proof of a health insurance premium. The due date for the information was April 28, 2016. On April 26, 2016, the agency received the requested verification.

28. On April 27, 2016, a notice of Information about Community Spouse Asset Share Calculation was issued by the agency to the Petitioner's representative. It informed her that total combined countable assets as of April 26, 2016 was $89,978.24.

29. On April 27, 2016, a Notice of Decision was issued to the Petitioner's representatives informing them that the MA application of January, 2016 was denied due to income and assets exceeding program limits. It further informed that the application for Community Waivers was denied due to assets exceeding the program limit.

30. In May, 2016, the Petitioner moved to a skilled nursing facility.

31. On May 7, 2016, an appeal was filed with DHA on behalf of the Petitioner. That appeal was designated as DHA Case No. MGE/174217.

32. On May 26, 2016, the agency determined that the asset assessment had been incorrectly calculated. On May 27, 2016, a Notice of Decision was issued informing the Petitioner that the MA application was approved for the period of December 1, 2015 – January 31, 2016 with $0 cost share. On May 27, 2016, a Notice of Decision was issued informing the Petitioner that the MA application was approved effective February 1, 2016 with a cost share of $1,527.39 for February, 2016 and a cost share of $1,693.39 effective March 1, 2016.

33. On June 2, 2016, a hearing was held with DHA for Case No. MGE/174217. A decision was issued on June 3, 2016 finding that no issue remained for determination. The decision stated: "This appeal was filed on petitioner's behalf . . . after onerous attempts to get him determined eligible for MA dating back to May, 2015. Prior to the hearing the agency determined that an incorrect asset assessment had been used, and using a correct assessment petitioner was eligible for MA effective December 1, 2015. The agency took action to make the petitioner eligible, and that action resolved the matter. I thus will dismiss the appeal as resolved."

34. On June 3, 2016, the Petitioner passed away.

35. On June 16, 2016, the Petitioner's representative spoke with [redacted] and informed the accounting department that the Petitioner had been approved for Family Care for December, 2015 – May, 2016. The accounting department informed her that the Petitioner's status was listed by the county agency as open for MA but not for Community Waivers/Family Care. Petitioner's representative was advised to contact the county agency.

36. On June 16, 2016, the Petitioner's representative attempted to contact the county agency. The call was not returned. On June 21, 2016, the Petitioner's representative contacted the agency again and was advised to contact DHA. Petitioner's representative contact DHA and was advised that payment is handled by the county agency. The Petitioner's representative contacted the county agency again and was again advised to contact DHA. The Petitioner's representative again contacted DHA. She was advised to file a death certificate with the county agency. She contacted the county agency again, was transferred to a supervisor, left a message and never received a return call.

37. During July and August, 2016, the Petitioner's representatives attempted to make contact on numerous occasions with the agency, a lawyer hotline, and an ombudsman. They were unable to get any help in resolving the issue of the Petitioner's eligibility for FC/Community Waivers.

38. On August 10, 2016, the Petitioner's representative filed an appeal on behalf of the Petitioner with the Division of Hearings and Appeals.

DISCUSSION

The Family Care program, which is supervised by the Department of Health Services, is designed to provide appropriate long-term care services for elderly or disabled adults. It is authorized in the Wisconsin Statutes, §46.286, and is described comprehensively in the Wisconsin Administrative Code, Chapter DHS 10.

> Wis. Admin Code, § DHS 10.31(6) Eligibility determination.
>
> (a) Decision date. Except as provided in par. (b), as soon as practicable, **but not later than 30 days from the date the agency receives an application** that includes at least the applicant's name, address, unless the applicant is homeless, and signature, the agency shall determine the applicant's eligibility and cost sharing requirements for the family care benefit, using a functional screening and a financial eligibility and cost-sharing screening prescribed by the department. If the applicant is a family care spouse, the agency shall notify both spouses in accordance with the requirements of s. 49.455 (7), Stats.
>
> (b) Notice. The agency shall notify the applicant in writing of its determination. If a delay in processing the application occurs because of a delay in securing necessary information, the agency shall notify the applicant in writing that there is a delay in processing the application, specify the reason for the delay, and inform the applicant of his or her right to appeal the delay by requesting a fair hearing under s. DHS 10.55.
>
> (emphasis added)

Wis. Admin. Code, §DHS 10.33(2) provides that an FCP applicant must have a functional capacity level of comprehensive or intermediate (also called nursing home and non-nursing home). The process contemplated for an applicant is to test his/her functional eligibility, then his/her financial eligibility, and if s/he meets both standards, to certify him/her as eligible. Then s/he is referred to a Managed Care Organization (MCO) for enrollment in the MCO. See Wis. Admin. Code, §§DHS 10.33 – 10.41. The MCO then drafts a service plan using MCO selected providers, designing a care system to meet the needs of the person, and the person executes the service plan. At that point the person's services may begin. With regard to the start date, Wis. Admin. Code, §DHS 10.36(1), provides that a person who meets all conditions of eligibility is entitled to enroll in an MCO. §DHS 10.36(2) provides that entitlement to the FC benefit first applies on the effective date of the contract between the MCO and the applicant:

> (a) Effective date. Except as provided in pars. (b) and (c), within each county and for each CMO target population, entitlement to the family care benefit first applies on the effective date of a contract under which a CMO accepts a per person per month payment to provide services under the family care benefit to eligible persons in that target population in the county.

Wis. Admin Code, §DHS 10.36(2)(a).

DHS explains the process for applying for Family Care as follows:

> 1. There are three steps to determine eligibility and enrollment in a Family Care MCO. The ADRC helps people with each step. The ADRC will visit the person and complete the Long Term Care Functional Screen to assess the person's level of need for services and functional eligibility for the Family Care benefit. Once the individual's particular needs for long-term care are determined, the ADRC will provide advice about the options available to him or her. Options may include enrollment in Family Care, Partnership, IRIS or a different long-term care program. Or the person could choose to receive services through the Medicaid fee-for-service system, or to privately pay for services.
>
> 2. If the person is interested in Family Care or another Medicaid program, the ADRC will help the person contact an income maintenance agency to determine financial eligibility.
>
> 3. Once functional and financial eligibility is established, the ADRC contacts the person, either by phone or in person. The ADRC makes sure the person understands what it means to become a member of the MCO, and that he or she understands all the options for long-term care available. If the person decides on Family Care, the resource center finishes the enrollment process and notifies the MCO of the enrollment date.

https://www.dhs.wisconsin.gov/familycare/apply.htm

Strictly applying the regulations concerning the date of Family Care enrollment can and has led to harsh results. With many entities involved—local agencies, the ADRC, and the CMO—applications sometimes get lost in the shuffle and the chance for error increases. When this happens, the potential recipient, through no fault of his own, does not receive benefits he is entitled to and must find his own financing for things such as nursing care and adult family homes. Because Family Care benefits are not retroactive, stringently applying the regulation that allows benefits only to those actually enrolled in a CMO does not allow the department or the Division of Hearings and Appeals to correct any error that might occur somewhere in the application process by paying for services the applicant has already received and was eligible for. The Division of Hearings and Appeals has issued a number of decisions upholding this type of result because it lacks equitable powers that would allow it to consider the fairness of the situation. See, e.g., DHA Decision No. FCP/163632.

In the last year, the DHS has issued some final decisions that mitigate the harshness of this interpretation. Although DHS' final decisions are not binding on the Division of Hearings and Appeals, the Division generally gives them significant weight and deference. Recently, DHS issued Final Decision No. FCP/173457. In that matter, the agency incorrectly calculated the applicant's assets, which led to an incorrect denial of Family Care benefits. The final decision reversed the denial and found the applicant eligible back to the date of his application. In doing so, it held: "Although there is no retroactive enrollment in the Family Care program, enrollment as of the date established in correction of an agency error is necessary and appropriate."

Another final decision, this one modifying a decision the Division of Hearings and Appeals issued October, 2016, found that enrollment in a CMO can begin "effective the actual date on which an individual completed an enrollment form and meets all eligibility and entitlement criteria, even if that date is earlier than the date on which the agency completes all its calculations/verifications and verifies the individual has met all financial and non-financial eligibility criteria." Final Decision No. FCP/167655. As an example, it noted that if a "person was determined to be functionally eligible on January 1st and also completed the MA application and the Family Care Enrollment form on January 1st, but the agency finishes its eligibility determination on February 5, 2015, and verifies the person met all financial, non-

financial eligibility criteria as of January 1st, there is nothing that precludes enrolling the person effective January 1st."

There are three points to take from this decision. First, enrollment can begin before the date the CMO actually accepts the person into the program. DHS noted that in these instances, the CMO could receive capitation payments to cover the cost of the service it provided before the person was formally accepted into the program. Of course, if the applicant loses his appeal, he may be responsible for those costs. The second point is that financial eligibility does not depend upon the date the applicant proves that he is financially eligible but rather on the date he actually met the financial requirements. Third, functional eligibility begins on the date a functional screen establishes that the person is functionally eligible. This is established by the language in Final Decision No. FCP/167655 that makes eligibility dependent on the date the person was determined to be functionally eligible." This refers to the date that the determination was made. If the department had meant for functional determinations to consider the person's functional ability before it was determined, the language would clearly state this as it did when referring to financial eligibility.

In this case, the Petitioner's functional eligibility was determined as of July 22, 2015. With regard to financial eligibility, after several incorrect determinations that the Petitioner was not financially eligible, the IM agency finally determined the Petitioner was financially eligible for MA as of December 1, 2015. This case has the same type of facts and circumstances as in Case No. 173457 cited above. There were numerous errors and delays in processing the Petitioner's application and eligibility (cited in detail in the Findings of Fact) which resulted in a delay in determining financial eligibility and a delay in enrollment in Family Care. The Petitioner's representatives presented sufficient evidence to demonstrate that they attempted to work with the IM agency and ARC and that they were diligent in their efforts to provide the necessary information for the processing of the applications. I conclude that the errors and delay were not caused by the Petitioner or his representatives. The errors were not corrected until the Petitioner's representatives filed for a fair hearing. As of the date of the hearing in June, 2016, the Petitioner's representatives believed the issue had been resolved. What they did not realize because they had not been informed was that Family Care and Community Waivers would not be back-dated to December 1, 2015. This had been the reason for their filing of the fair hearing request and they were led to believe that the correction of the errors made in determining Petitioner's financial eligibility would resolve the issue of his eligibility for Family Care/Community Waivers as of December 1, 2015. The lack of proper information and notice to the Petitioner and his representatives resulted in further delays and misunderstanding.

Thus, I conclude that this is a case in which the holding from the Department of Health Services' final decision of FCP/173457 noted above is appropriate: "Although there is no retroactive enrollment in the Family Care program, enrollment as of the date established in correction of an agency error is necessary and appropriate." In this case, the Petitioner was functionally and financially eligible for Community Waivers/Family Care as of December 1, 2015 and should have been enrolled effective December 1, 2015.

CONCLUSIONS OF LAW

The Petitioner was functionally and financially eligible for Community Waivers/Family Care as of December 1, 2015 and should have been opened for Community Waivers and enrolled in Family Care effective December 1, 2015.

THEREFORE, it is ORDERED

That this matter is remanded to the IM agency and the ARC to take all administrative steps necessary to revise its records to show Petitioner's effective date of enrollment in Community Waivers and the Family

Care program is December 1, 2015. These actions shall be completed within 10 days of the date of this decision.

REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision.** Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Milwaukee,
Wisconsin, this 12th day of January, 2017

\s_____
Debra Bursinger
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
Suite 201
5005 University Avenue
Madison, WI 53705-5400

Telephone: (608) 266-3096
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on January 12, 2017.

Milwaukee Enrollment Services
Office of Family Care Expansion
Health Care Access and Accountability